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Published in:
Community Dentistry and Oral Epidemiology

DOI:
10.1111/cdoe.12500

Publication date:
2020

Document Version
Peer reviewed version

Inclusion oral health: advancing a theoretical framework for policy, research and practice

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Key words:

inclusion oral health, social exclusion, intersectionality, othering, extreme oral health

Author contributions:

All authors were involved with the conceptualization of the paper, drafting and critically reviewing the manuscripts. All authors contributed and approved the final manuscript.

Abstract

In response to headlines about the oral health of persons experiencing social exclusion resonating in high-income countries, and research demonstrating the need for urgent action, a symposium entitled 'International Perspectives on Socially Inclusive Dentistry: A Call to Action' was organized for the IADR International Meeting of 2018. The aim of the symposium was to initiate an international dialogue on barriers to care, multidisciplinary action, and examples of best practice for service delivery for people experiencing social exclusion; in other words, to develop the idea of inclusion oral health. Through our international exchange, what emerged was an awareness of a lack of professional consensus: What exactly is inclusion oral health? A theoretical framework to push forward the policy, research and practice agenda was clearly needed.

This paper advances such a framework. Over the decades, dentistry has forged an approach to service delivery mainly through a business, demand-led model. While oral health continues to improve globally, an important consequence of this approach is that it compounds the social exclusion that many people are already experiencing because of a constellation of economic, political, cultural and individual factors. Thus, many people are simply not getting the dental care they need. In contrast, drawing on the theoretical literature on social exclusion, intersectionality and othering, we suggest that dentistry could act as an agent for social inclusion as a more responsive, all-encompassing form of oral health care and delivery. This paper advances a theoretical framework for inclusion oral health and an action plan to show how inclusion oral health may become one solution in an armamentarium to tackle the global phenomena of oral health inequities.

Introduction

The social gradient in health reflects the health and social inequalities in society seen globally. The social gradient is governed by how the social determinants of health impact upon people's health at societal, community, interpersonal and individual levels[1]. In seeking to tackle social inequalities, some population-based programmes[2], based upon proportional universalism, have shown improvements in the overall health of the population but have produced little change in the actual slope of the social gradient. Persistent and pervasive disparities continue to exist[3]. Careful examination reveals that those individuals falling at each end of the social gradient 'appear to be on a different scale'[4] than those in the middle. While the same social determinants of health are implicated across the hierarchy, those at the lower end seem to be more acutely affected by the 'causes of the causes' of ill-health.

As a consequence of a number of socio-political phenomena, manifesting as adverse childhood experiences, difficulties with literacy and numeracy, mental health problems, discrimination and prejudice[5,6], people at the lowest end of the social gradient are vulnerable, with a higher propensity of becoming socially excluded. Disengaging from mainstream preventive and treatment services[6,7], their health status falls steeply with an increased prevalence of co-morbidities leading to premature death[6] – the 'so-called cliff-edge of inequality'[8]. The magnitude of their ill-health experience has been named 'extreme health'[6]; extreme health is embedded in multiple social inequities[6]. Luchenski et al[7] proposed a new type of holistic health care called 'inclusion health', specifically aimed at tackling extreme health to 'redress health and social inequities among the most vulnerable and marginalised in a community'[7,9].

An equivalent phenomenon exists when one considers people's oral health. People experiencing multiple social exclusions have what could be called ''. Extreme oral health is characterised by an increased risk of oral cancer[10], rampant dental caries, dental pain, many missing teeth[11,12], and is compelled and compounded by reduced access to mainstream dental services[12-15]. Inspired by Luchenski et al,[7] this paper advances a new form of oral health care to respond to extreme oral health, called 'inclusion oral health'. To develop the idea of inclusion oral health, we start by building a theoretical framework drawing on social exclusion, intersectionality, othering and dental care systems drivers. This exploration of social exclusion, intersectionality, othering and dental care systems drivers, demonstrates that people who experience social

exclusion and multiple intersecting vulnerabilities face a "triple separation". They are, first, separated from mainstream society, living at the 'cliff-edge' of the social gradient. Second, they are stigmatized by dental care professionals and experience othering. Finally, the reliance on charitable dental service provision and the separation of dental care from health and social care systems further separates people experiencing social exclusion from the institutions where their health and social care problems should be addressed. We propose a definition of inclusion oral health and an action plan for how dentistry may evolve to be an agent of inclusion oral health. This, we believe, will develop a more responsive, and inclusive model of service delivery.

[1] The concept of social exclusion

The expression 'social exclusion' was first mentioned in 1974 by Rene Lenoir, the Secretary of State for Social Action in France. Lenoir[16] conceptualised social exclusion as a phenomenon affecting people who were at risk of being, or who were, excluded from employment and citizen rights. By the 1990s, Room[17,18], a social policy theorist, had reformulated social exclusion, conceptualizing it as composed of 'three fundamental elements'[19]: multidimensional, dynamic and relational. The multidimensional element considers all aspects of poverty, including social, economic, cultural, and political factors that operate at macro, meso and micro levels. The dynamic element recognizes the changing and interactive nature of social exclusion along different dimensions and at different levels over time[19]. Social exclusion is not static and is not experienced by people in the same way[20] or to the same extent; therefore time, place, and context matter. The relational element refers to the actual 'exclusionary processes' caused by 'unequal power relationships'[21] that operate across economic, political, social and cultural milieu. These exclusionary processes can be evident at the individual, household, country and global levels, and serve to reduce social capital, social interactions and relationships with others[21]. Moreover, 'these exclusionary processes create a continuum of inclusion/exclusion characterised by unjust distributions of resources, capabilities and rights, i.e., socio-economic inequalities that in turn generate health inequalities.' [21]

The multidimensional and relational elements provide a way to understand the relationship between social exclusion and social and health inequities. The European Union (EU) Social Policy White Paper in 1994 operationalized Room's conceptual framework, focusing on stigma, ethnicity, culture and discrimination[22].

This new social policy thus heralded a shift from a static, narrow, individualistic view of poverty to one that theorized poverty as a dynamic, relational and multidimensional measure of disadvantage. Further, it acknowledged that social marginalisation acted to exclude people from social interactions with family and friends, from education, from work, from goods, and from health services[23,24]. Overall, the purpose of the White Paper was to prevent and tackle social exclusion by mobilising 'economic and social measures'[15] across Europe. The White Paper, and the policies and practices that followed, supported the importance of the social determinants of health, expounding the effect of 'fragility', 'detachment' and the lack of 'resources of the individual, household and community'[18] as central to understanding the causes and results of social exclusion.

The theory of social exclusion is internationally accepted as a dynamic, multidimensional and relational process, through which political and societal structures, together with interpersonal factors, affect people's experience and intensity of marginalization. This complex phenomenon, includes: [i] individuals who are or who are at risk of being excluded; [ii] people who are excluded from goods and services; [iii] the health and social problems associated with exclusion; [iv] the processes driving exclusion; and [v] the 'agents and actors' involved in exacerbating exclusion[19].

[2] The concept of intersectionality

The concept of intersectionality helps to unpack the complexity and multidimensional and dynamic nature of social exclusion discussed in the previous section. Intersectionality proposes that people who endure exclusion experience multiple forms of discrimination, stigma and disadvantage that are neither isolated nor independent, instead reflecting intersecting social identities[25]. For example, people experiencing exclusion include: those who are isolated due to older age, have learning disabilities, endure homelessness, are in custody or have convictions, are migrant workers, are refugees, asylum seekers, sex workers, victims of slavery, have substance use disorders, and have mental health conditions. While each group will experience discrimination in unique forms (e.g., ageism, ableism, sexism, racism, prejudice), each individual will also experience multiple forms of discrimination depending on their social markers (e.g., gender, race, ethnicity and sexuality[26]). These layers of discrimination accumulate and compound social exclusion. Intersectionality

thus provides an important lens for thinking about the complexity of how people experience social exclusion in that intersectionality underscores the multiple dimensions and complexities of inequality[27].

[3] The concept of othering

The dental clinic environment provides a clear illustration of how social exclusion and intersectionality can operate to affect health outcomes. In a clinical practice setting, social interactions necessarily occur between dental professionals and patients. When such social interactions have an 'us versus them mentality,'[28] that is, between dental professionals and people who already are experiencing social exclusion, this dynamic can gives rise to 'othering'[29]. Othering is conceptualised as having three parts, which together create a social chasm: [1] making judgements about the other; [2] isolating the other; and [3] misunderstanding the other[30]. Otto has expanded the notion of othering, proposing that othering is exacerbated by the 'social gulf between dentists and poor patients'[31]. It is this social gulf, in terms of the dentists' financial and knowledge capabilities, she insists, that creates and maintains a power imbalance. The power differential contributes to the exclusion of people with perceived 'undesirable' or 'deviant' characteristics, with devastating consequences[31].

Mago et al[32] describes the 'othering' experiences of people enduring homelessness. Being criticized by dentists for neglecting their oral health[33] and feeling that they are literally 'being pushed out of the door'[12], *others* these dental clients. Similarly, people living with HIV anticipate and suffer stigma, discrimination and being treated differently by the dental profession[34,35]. They describe their experience of dental professionals as disengaging and providing inappropriate and poorer quality care[36]. When dentists avoid treating people on Medicaid[31], when they judge people for missing appointments and frame those choices as a result of 'chaotic lifestyles'[37], when they make judgements about how people value their teeth, then they are failing to appreciate the impact of intersectionality and the multiple vulnerabilities that increase the complexity of the lives of people who are socially excluded[38-40]. Such misunderstandings promote 'othering' which reinforces social exclusion[39] and brings prejudice, intolerance and judgment into the dental clinic[32].

[4] Dental care systems drivers

Underpinning othering within dentistry is the supply and demand culture of current dental care systems[40]. Dental care systems operate on a business model of service and delivery with remuneration directly linked

to financial cost and quantity of an individual's treatment. Dental care serves those who seek and can pay for treatment[41]. For those on low income, those without insurance, and those who cannot access publicly sponsored care, dental treatment can feel like a luxury. For many, treatment costs are prohibitive[42-44], and for some, dental care is impossible, as dentists decide who they accept as their patients[31]. Professional territorialism is bound-up in the supply and demand of current practice systems and contributes to the marginalisation and othering of people from mainstream dental care.

To address these inequities in service provision and advance more flexible models of dental practice, some social health care programmes and publicly-funded services have been developed. Community-based dental programmes, such as government-funded salaried dental practices, provide a safety net for people with low income and who experience multiple exclusion[45,46]. Charitable models have also been created to provide dental services for people experiencing social exclusion[47]. While laudable for attending to people's dental needs, the provider-driven volunteerism and charity that characterizes many oral health outreach models do not disrupt the fundamental inequity that undergirds oral health disparities. Over a decade ago, Mouradian[48] debunked the myth that dental charity could solve the "access crisis" and oral health inequities. *'*Reliance upon dental charity is conceptually flawed*'*, she wrote; 'it is not morally defensible as a model of service delivery*'*[48]. The charity care model is provider-centred, not patient-centred, and as such, it encourages dependency instead of promoting service-user empowerment. The charity model of dental care cannot lead to systemic change within policy or within the profession. These 'Band-aid solutions'[48] do not oblige government, policy drivers or the profession, to increase workforce capacity or provide equitable distribution of services to enable dentistry to engage with the complex issues associated with exclusion. A systemic barrier, therefore, remains for those experiencing social exclusion and for those who require holistic health and social care interventions that reflect their experience of intersectionality.[49]

In the lexicon of social exclusion, despite the efforts of social care programmes, third sector organisations, and charities to configure inclusive dental practice, governments and the profession have maintained an inequitable distribution of oral health facilities, services and treatments. To quote Watt and colleagues[50], 'dentistry and oral health-care systems need radical reform. The current outdated and treatment-focused approach is not meeting the oral health needs of large segments of the global population, and is

inappropriate and unaffordable for most low-income settings. A different approach is now needed'. Inclusion oral health is therefore a call for reform, for 'high-quality and essential services' [21] and for government and the profession to act as agents for inclusion and lobby for holistic clinical practices.

Inclusion oral health: an action plan for education, research and practice

In this paper we have responded to the lack of professional consensus regarding what is inclusion oral health by providing a theoretical overview of social exclusion, intersectionality and othering and examining care systems drivers. It is through a distillation of the essential elements of these constructs that we better understand the complexity of the multidimensional, dynamic and relational dimensions of social exclusion. Together, these constructs theorize how and why exclusion is created, and how it is experienced; how the intersection of discrimination compounds oral health inequities; and how current dental care systems promote othering and dental care exclusion.

Following, as a next step in building an inclusion oral health framework, we propose a definition of inclusion oral health:

> *Inclusion oral health is based on a theoretically-engaged understanding of how social exclusion is produced and experienced, and how forms of exclusion and discrimination intersect to compound oral health outcomes. Inclusion oral health focuses on developing innovative inter-sectoral solutions to tackle the inequities of people enduring extreme oral health*.

The next step in building this framework is to begin to operationalise the definition of inclusion oral health across three key action areas of [1] health and social care policy and service delivery, [2] research, and [3] dental education. We propose the following:

[1] Health and social care policies must call for high quality oral health and health care services: that is, for system delivery models to be reformed and reconfigured for the integration and incorporation of oral health into health and social care, and for skills mix in service delivery systems to be promoted to enable inclusion oral health for all. Therefore, when oral health is incorporated into health and social care policies, and when these policies adopt a co-design or co-production strategy involving people who experience social exclusion, the influence of the multidimensional, dynamic and relational processes are acknowledged as central to the planning of innovative inter-sectorial services to promote inclusion.

[2] The research action area underscores the importance of having an evidence-based action plan informed by mixed research methodologies and undergirded by Participatory Research paradigms[51,52] in order to privilege the voices and lived experiences of people experiencing social exclusion and extreme oral health. This research moves beyond deficit models and research that only reports on the associations between marginalised groups and deprivation markers[53]. Research is needed to provide an evidence-base to inform policy decisions,[53] to identify the reconfiguration of dental services, and to support the development of innovative solutions, such as to tackle extreme oral health suffered by those with multidimensional disadvantage. Thus, when research is informed by the evidence of experts by experience, it recognises the importance of the dynamic and relational elements of exclusion to underpin service reconfiguration.

[3] The dental education action focuses on education and training of undergraduate, postgraduate and qualified dental health professional levels to raise awareness of social exclusion, intersectionality, and othering in order to foster and advocate for inclusion oral health[54-58]. Dental education that emphasizes the theoretical and practical dimensions of extreme oral health for oral health providers has the potential to reduce the intensity of exclusion faced by people when they access dental services.

Conclusion

Inclusion oral health is underpinned by social exclusion, intersectionality and othering theories. We have proposed an inclusion oral health framework for all those interested in helping people marginalized by social exclusion. We believe that it is by providing a theoretical framework to situate a cogent policy agenda, together with an action plan for new service systems based on the research evidence, that the central tenants of inclusion oral health can ensure that dentistry will become an agent to tackle the global phenomena of extreme oral health and the social inequities that follow social exclusion.

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